

I CERTIFY THAT THIS IS A TRUE COPY OF THE CERTIFICATE RECEIVED FOR RECORD

ATTEST: *Debbie Aurelia Holstead* REGISTRAR

VS-4ME 4/04 STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH		CERTIFICATE OF DEATH OFFICE OF THE CHIEF MEDICAL EXAMINER		STATE FILE NUMBER	
1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last) Adam Peter Lanza			2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Best Month) December 14, 2012	4. ACTUAL OR PRESUMED TIME OF DEATH 11:00 AM
5. Age at last birthday 20	6. Under 1 Year Mo. Days Hours Mins April 22 1992	7. Date of Birth (MM/DD/YYYY) April 22 1992	8. BIRTHPLACE (City, State or Foreign Country) Exeter NH		
9. RESIDENCE-STATE Connecticut		10. RESIDENCE-COUNTY Fairfield		11. RESIDENCE-CITY OR TOWN Newtown	
12. RESIDENCE-ADDRESS (2nd line) 36 Yogananda St		13. ZIP CODE 06470	14. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		15. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married but Separated <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown
16. FATHER'S NAME (First, Middle, Last) Peter Lanza			17. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Nancy Champion		
18. INFORMANT'S NAME Peter Lanza		19. INFORMANT'S RELATIONSHIP TO DECEDENT Father		20. MAILING ADDRESS (Street and Number, City, State, Zip Code) 100 Bartina Ln Stamford CT 06902	
21. IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Dead on Arrival			22. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Home <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (specify) Public School		
23. CITY OR TOWN OF DEATH & ZIP CODE SANDY HOOK 06482		24. COUNTY OF DEATH FAIRFIELD		25. MANNER OF DEATH <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Conviction <input type="checkbox"/> Drowning <input type="checkbox"/> Gunshot <input type="checkbox"/> Poisoning <input type="checkbox"/> Suffocation <input type="checkbox"/> Other (specify)	
26. DISPOSITION (Place of interment, crematory, other place) Lirwood Crematory		27. LOCATION (City or Town) Haverhill MA		28. DATE OF DEATH (MM/DD/YYYY) 12/27/2012	
29. SIGNATURE OF FUNERAL DIRECTOR (Print Name) Hartford Trade Service Co Inc		30. SIGNATURE OF CHIEF MEDICAL EXAMINER <i>[Signature]</i>		31. LICENSE NUMBER OF GRANTEE BY BOX 34 2698	
32. DATE OF DEATH (MM/DD/YYYY) 12-17-2018		33. TIME OF DEATH 12/14/2012 11:00 AM		34. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
35. CAUSE OF DEATH a. Enter the date of onset, duration, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or convulsions that follow without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. Gunshot Wound of Head Due to (or as a consequence of): b. Enter the UNDERLYING CAUSE (Immediate or injury that initiated the events resulting in death) LAST Self Inflicted Due to (or as a consequence of): c. Enter the IMMEDIATE CAUSE (Final disease or condition resulting in death) LAST Self Inflicted Due to (or as a consequence of):				36. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
37. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. Suicide		38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 43 days of death		39. PLACE OF INJURY (Specify) School, Primary or Secondary	
40. MANNER OF DEATH (Suicide, Homicide, Accident, Death, Unknown/Undetermined) Suicide		41. DATE OF INJURY December 14, 2012		42. TIME OF INJURY AM	
43. LOCATION OF BURY (Street, Apt. #, City or Town, State, Zip Code) 12 Dickinson Dr., Sandy Hook, CT		44. DECEASED HOW BURY OCCURRED Self Inflicted		45. IF TRANSPORTATION INJURY, SPECIFY <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other specify	
46. CERTIFIER: (Print Name, Title, Date) H. Wayne Carver, II, M.D.		47. SIGNATURE OF CHIEF MEDICAL EXAMINER <i>[Signature]</i>		48. TITLE OF CERTIFIER Chief Medical Examiner	
49. MAILING-CERTIFIER: (Street, Apt. #, City or Town, State, Zip Code) Office of the Chief Medical Examiner, 11 Shuttle Road, Farmington, CT 06032-1939		50. CITY OR TOWN Farmington		51. STATE CT	
52. THIS CERTIFICATE WAS REVIEWED FOR RECORD ON 1-3-13		53. BY <i>Debbie Aurelia Holstead</i>		54. REGISTRAR Debbie Aurelia Holstead	
55. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed as the basis of death. <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9-12th grade, no diploma <input checked="" type="checkbox"/> High School Graduate/GED <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate or Professional degree <input type="checkbox"/> Unknown <input type="checkbox"/> Not available		56. DECEDENT OF HISPANIC ORIGIN: <input type="checkbox"/> White, Not Spanish/Spanish/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes other Spanish/Spanish/Latino (specify)		57. DECEDENT OF OTHER ORIGIN: <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principle tribe) <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Guatemalan or Chonteco <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (specify) <input type="checkbox"/> Other (specify)	
58. DECEDENT'S SOCIAL OCCUPATION Never Worked		59. KIND OF BUSINESS/INDUSTRY N/A		60. SOCIAL SECURITY NUMBER	